

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8485

Item 2 Film G291 7/24/61 iwk

08479

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boonsboro/Hagerstown, d. STREET ADDRESS 248 S. Prospect St. Fahney-Keedy Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) BLANCHE SEIBERT ANKENEY			4. DATE OF DEATH July 15 1961 19		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25 1874	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Md. Clear Spring Wash Co	
12. CITIZEN OF WHAT COUNTRY? USA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Ankeney			14. MOTHER'S MAIDEN NAME Sallie Seibert		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No --			16. SOCIAL SECURITY NO. None		
17. INFORMANT Bayard W. Goslin 31 Red Oak Drive			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Thrombosis & left hemiplegia DUE TO Generalized & cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic Heart Disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 12-8, 1945 to 7-15, 1961, that (I) (we) last saw the deceased alive on 7-15-61, 1961, and that death occurred at 12-45 P.M. from the causes and on the date stated above.					
22a. SIGNATURE John H. Hornbaker, M.D.			22b. DATE SIGNED 7-17-61		
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.			22d. ADDRESS 154 West Washington St., Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/19/61		23c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery	
23d. LOCATION (City, town or county)		(State)		23d. LOCATION (City, town or county) near Clear Spring Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.			25a. REC'D BY REGISTRAR JUL 19 '61		
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			25b. REGISTRAR'S SIGNATURE		

3883

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Arthur E. Gellman, Hagerstown, Md.

John H. Hornbaker, D.C.

Isa. Pops, Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8485 CERTIFICATE OF DEATH 08480											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 1/2 Hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 4</u> d. STREET ADDRESS <u>Resh Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES OMER ARNSPARGER Sr</u>				4. DATE OF DEATH Month Day Year <u>July 18 1961 19</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14 1884</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern Owner-operator</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Thurmont Fred. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Arnsparger</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Eby</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Anna W Arnsparger Hagerstown R # 4</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema and</u> <u>260 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cardiac Decompensation</u> (c) <u>Diabetes Mellitus + Asterosclerotic Heart</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Benign prostate hypertrophy -</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>July 1, 1961</u> , to <u>July 18, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 18, 1961</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward W. Ditto III</u>				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/19/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>				22d. ADDRESS <u>217 West Washington St.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) <u>Hagerstown Wash Co Md.</u>		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Maryland</u>				ADDRESS		DATE <u>JUL 24 '61</u>					

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DR. PACKER
145 W. WASHINGTON ST.
HAGERSTOWN, MD.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8487

08481

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>7 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>219 ROBIN WOOD DRIVE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>219 ROBINWOOD DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GLADYS LILLIAN BAIR</u> First Middle Last 4. DATE OF DEATH <u>JULY 13 1961</u> Month Day Year		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAY 19 - 1898</u> 9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MAPLEVILLE WASH. CO. MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM HOFFMAN</u> 14. MOTHER'S MAIDEN NAME <u>LOTTIE SINNISEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> 16. SOCIAL SECURITY NO. <u>200-01-1789</u> 17. INFORMANT <u>MRS. J. E. CUNNINGHAM</u> Address <u>219 ROBINWOOD DRIVE HAGERSTOWN MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443X DUE TO (b) <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>10 years +</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hagerstown, MD</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1961</u> to <u>July 13, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 13, 1961</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>L. L. Packer Jr</u> 22c. PHYSICIAN'S NAME (Type) <u>L. L. Packer Jr</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Hagerstown, MD</u> 22b. DATE SIGNED <u>7/14/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>July 15, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN WASH. CO. MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>BOGNSBORO MD.</u> 25a. REC'D BY REGISTRAR <u>DATE JUL 19 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8488 Item 23d, Film G292 8/7/61 iwk 08482											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BENEVOLE - RURAL</u> c. LENGTH OF STAY IN 1b <u>65 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BOONSBORO MD. R.I.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BENEVOLE - RURAL</u> d. STREET ADDRESS <u>BOONSBORO MD. R.I.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ANNIE S. BAKER</u>				4. DATE OF DEATH <u>JULY 29 - 1961</u>				5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>OCTOBER 25 - 1866</u> 9. AGE (In years last birthday) <u>94</u> yrs. IF UNDER 1 YEAR Months <u>9</u> Days <u>4</u> Hours <u>4</u> Min.				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WASH. CO. MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>JACOB STINE</u> 14. MOTHER'S MAIDEN NAME <u>NANCY GREENAWALT</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>MRS. GERALD BOWERS BOONSBORO MD. R.I.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart D.</u> <u>420.0</u> DUE TO (b) <u>general arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>June 28, 1958</u> Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Boonsboro</u> (County) <u>Forkstown</u> (State) <u>MD.</u>											
21. I certify that (I) (this hospital) attended the deceased from <u>June 28, 1958</u> to <u>July 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 29, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Sidney Novenstein</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u> 22d. ADDRESS <u>Forkstown MD.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7-31-61</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>AUG. 1, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u> 23d. LOCATION (City, town or county) <u>Dr. Tilghmanton, Wash. Co. Md.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u> ADDRESS <u>Boonsboro MD.</u> 25a. REC'D BY REGISTRAR <u>DATE AUG 3 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Anthony S. Kraus</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8489
08483
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>921 D Main Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Harold</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1961</u>
9. AGE (In years last birthday) yrs. <u>16</u>		10. IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Warren D. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Esther U. Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Warren D. Baker</u>		Address <u>921 D Main Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>7-7</u> <u>1961</u> , to <u>7-8</u> <u>1961</u> , that (I) <u>last</u> saw the deceased alive on <u>7-8</u> <u>1961</u> , and that death occurred at <u>2:40 P.</u> M., from the causes and on the date stated above. 22a. SIGNATURE <u>E. Margaret Sullivan</u> M.D. 22b. DATE SIGNED <u>7-10-61</u> 22c. PHYSICIAN'S NAME (Type) <u>E. MARGARET SULLIVAN</u> 22d. ADDRESS <u>314 N. POTOMAC Hagerstown Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 10, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>		ADDRESS <u>Hagerstown, Md.</u>	
25a. REC'D BY REGISTRAR <u>AUG 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

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WASHINGTON COUNTY HOSPITAL

WASHINGTON COUNTY HOSPITAL

William J. White

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08484											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 wks. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garlock Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Penna b. COUNTY Franklin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro d. STREET ADDRESS 27 Cleveland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First CORA Middle Barnhart Last Barnhart						4. DATE OF DEATH Month July Day 5 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1881		9. AGE (In years, last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 5 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David B. Wishard						14. MOTHER'S MAIDEN NAME Clara Koons					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Mr. Ralph Barnhart		Address Waynesboro, Penna.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO general arteriosclerosis with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) arteriosclerotic heart disease (c) Senility due to above & biological										INTERVAL BETWEEN ONSET AND DEATH 5 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility due to above & biological											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 29, 1961 to July 5, 1961 , that (I) (we) last saw the deceased alive on July 5, 1961 , and that death occurred at 11:28 AM , from the causes and on the date stated above.											
22a. SIGNATURE Edward W. Ditto III M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/7/61			
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.						22d. ADDRESS 217 West Washington St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/61		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City, town or county) (State) Waynesboro, Penna.					
24. FUNERAL DIRECTOR'S SIGNATURE Walter J. Harte				ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR JUL 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8491

CERTIFICATE OF DEATH

08485

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 407 Sherwood Drive				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Penna b. COUNTY Northumberland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Watsonstown R.F.D. d. STREET ADDRESS ----									
3. NAME OF DECEASED (Type or print) CARRIE BENNETT BELFORD				4. DATE OF DEATH Month Day Year July 20 1961 19									
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 16 1883		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (Country & State, or foreign country) Jefferson Co Pa.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Bennett				14. MOTHER'S MAIDEN NAME Ella Pope				17. INFORMANT Address Mrs Eva Schlotterbeck 407 Sherwood Dr Hagerstown Md. Jefferson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) --				16. SOCIAL SECURITY NO. None				18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 8-26-59		(County) 7-20-61		(State)			
21. I certify that (I) (this hospital) attended the deceased from July 20, 1961 to July 20, 1961 that (I) (we) last saw the deceased alive on July 20, 1961 and that death occurred at 8 P.M. from the causes and on the date stated above.													
22a. SIGNATURE R.A. Bell				22b. DATE SIGNED 7-21-61				22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.					
22d. ADDRESS Hagerstown, Maryland.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/22/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md					
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR JUL 24 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08486

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in 1b 18 Hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1113 Fairview Rd.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 313 West 29th St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY WILMER BOCK		4. DATE OF DEATH Month Day Year July 23 1961 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 25 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 60 yrs. 11. BIRTHPLACE (County & State, or foreign country) Waynesboro Franklin Co Pa
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry J. Bock	
14. MOTHER'S MAIDEN NAME Mary Rummell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.# 1	
16. SOCIAL SECURITY NO. 150-10-2611		17. INFORMANT Mrs Geneva W. Bock 213 W. 29th St Baltimore 11 Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 7 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 22, 1961 to July 23, 1961 , that (I) (we) last saw the deceased alive on July 22, 1961 , and that death occurred at 6:25 AM , from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III 22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22b. DATE SIGNED 7/24/61 22d. ADDRESS 217 West Washington St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/26/61	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR JUL 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kiana			

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Andrew J. Collins, Hagerstown, Md.

David J. Clark, West Haven, Connecticut

Edward M. Gatto, III, N. D.

Edward W. Gatto, Jr.

July 21, 1962

Dear Mr. Gatto:

I am writing to you regarding the information that you have provided to me regarding the activities of the "Black Liberation Army" (BLA) in the Washington, D.C. area.

I am sorry that I cannot provide you with more information at this time, but I am sure that you will understand the need for discretion in this matter.

I am sure that you will find this information helpful in your ongoing efforts to combat the activities of the BLA.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8493
CERTIFICATE OF DEATH
08487

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 4 Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville d. STREET ADDRESS Reid Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNIE EDMONDS BOWER				4. DATE OF DEATH July 19 1961 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 7 1877 yrs. Months Days	
9. AGE (In years last birthday) 84		10. AGE (In years last birthday) 84		11. BIRTHPLACE (County & State, or foreign country) Frederick Frederick Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eyster Edmonds				14. MOTHER'S MAIDEN NAME Ida Rice			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs Hazel Spielman Address 1010 Hamilton Blvd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 443X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Hypertension Cardio Vascular Dis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 2 days 10 yrs						INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-19-61 to 7-19-61 , that (I) (we) last saw the deceased alive on 7-19-61 , 19 61 , and that death occurred 4:30 M, from the causes and on the date stated above.							
22a. SIGNATURE A. E. W. T. T. T.				22b. DATE SIGNED 7-19-61		22c. SIGNATURE A. E. W. T. T. T.	
22d. ADDRESS Hagerstown Md				22e. ADDRESS Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 22 1961		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick Frederick Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				24. ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR JUL 24 '61 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanks				25c. REGISTRAR'S SIGNATURE Arthur S. Hanks			

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Handwritten notes and signatures, including "The E. W. Smith" and "The E. W. Smith" in large script.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8494

08488

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN lb <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK - RURAL</u> d. STREET ADDRESS <u>HAGERSTOWN MD. R.1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROY GEORGE BRANDENBURG</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1961</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>FEB. 13 - 1880</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>14</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE - NORTH AMERICAN CEMENT CO.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>WOLFVILLE FRED. CO. MD. U.S.A.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WOLFVILLE FRED. CO. MD. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>LEVI H. BRANDENBURG</u> 14. MOTHER'S MAIDEN NAME <u>LOUISE GROSSNICKLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>213-10-6919</u> 17. INFORMATION <u>MRS. LELA BRANDENBURG HAGERSTOWN MD. R.1</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>260X</u> DUE TO <u>arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes Mellitus</u> (c) <u>Hypertensive vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14</u> 19 <u>57</u> to <u>Aug 27</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 27</u> 19 <u>61</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip J. Hirshman</u> 22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>				22b. DATE SIGNED <u>7/28/61</u> 22d. ADDRESS <u>159 W. Washington St. Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 30 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. East</u>		25a. REC'D BY REGISTRAR <u>Boonsboro MD.</u> DATE <u>JUL 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
ISM 9/59

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8495
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08489

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown RFD 2		c. LENGTH OF STAY IN 1b 3 1/2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Williamsport			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home Inc.				d. STREET ADDRESS 1 Conococheague Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emery Middle Grafton Last Brown				4. DATE OF DEATH Month July Day 2 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10 1888	
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months 11 Days 21		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Coal Yard		11. BIRTHPLACE (State or foreign country) Williamsport Md. dist.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George Brown				14. MOTHER'S MAIDEN NAME Susan Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War I none		17. INFORMANT Mrs. Annie Kreps Conococheague St. Williamsport Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 7/2/61							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/2/61 to 7/2/61 , 19 61 , that (I) (we) last saw the deceased alive on 7/2/61 , 19 61 , and that death occurred at 7/2/61 M, from the causes and on the date stated above.							
22a. SIGNATURE L. F. Young				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/4/61	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 5-61		23c. NAME OF CEMETERY OR CREMATORY Otterbine Cemetery		23d. LOCATION (City, town, or county) (State) Near Williamsport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leg Williamsport, Md				25a. REC'D BY REGISTRAR DATE Jul 6 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

Handwritten: - Handwritten note or signature.

2/2/7.

7/10/15

5. 7. 1949

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8495
8495
08490
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>9 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>State Line</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co Hospital</u>				d. STREET ADDRESS <u>State Line</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>D.</u> Last <u>Byers</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 1, 1905</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeping</u>			
13. FATHER'S NAME <u>Jacob Stine</u>				14. MOTHER'S MAIDEN NAME <u>Ada Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. J. Franklin Byers</u> Address <u>State Line, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Emboli</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Thrombosis of L. Ventricle</u> DUE TO (c) <u>Coronary Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>6 yrs</u> <u>6 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>1961</u> that (I) (we) last saw the deceased alive on <u>August 4, 1961</u> and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>18 July 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul F. Webster, M.D.</u>				22d. ADDRESS <u>27 S. Carlisle St., Greencastle, Penna.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/19/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beautiful Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington Co Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. Zimmerman</u>				ADDRESS <u>Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Thane</u>	
DATE <u>JUL 21 '61</u>				25b. REGISTRAR'S SIGNATURE			

(M)

(1)

[Faint, mostly illegible handwritten text, likely a deed or certificate of sale, covering the majority of the page.]

IN WITNESS WHEREOF

I, the undersigned, have hereunto set my hand and seal at the County of ... State of ... this ... day of ... 1898.

[Faint handwritten text at the bottom of the page, possibly a signature or additional notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
8497									
08491									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 1/2 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Jackson Convalescent Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1125 North Locust Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>HENRY ARLINGTON COCHRANE</u>					4. DATE OF DEATH <u>July 19, 1961</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1877</u>		9. AGE (In years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Platform Foreman (Retired) R.E.A.</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown Wash. Co. Md.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>USA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>					13. FATHER'S NAME <u>David Cochrane</u>				
14. MOTHER'S MAIDEN NAME <u>Catherine H. Gantz</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				
16. SOCIAL SECURITY NO. <u>714-05-6869</u>					17. INFORMANT <u>Mrs. Anna U. Cochrane</u> Address <u>125 N. Locust St Hagerstown Wash. Co. Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Disease</u> (c) <u>10 per</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 days</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6-17-61</u> , 19 <u>61</u> , to <u>7-19</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-18</u> , 19 <u>61</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>A. E. W. Dittor</u>					22b. DATE SIGNED <u>July 24 '61</u>				
22c. PHYSICIAN'S NAME (Type) <u>A. E. W. Dittor</u>					22d. ADDRESS <u>Hagerstown Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash. Co. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>					25a. REC'D BY REGISTRAR <u>JUL 24 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

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ANDREW R. GORTON, HARTFORD, CT.

1912

THE F. W. DUFFY
F. W. DUFFY
F. W. DUFFY

Confidential

1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8493

CERTIFICATE OF DEATH

08492

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN lb <u>45 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		d. STREET ADDRESS <u>106 E. Salisbury St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 E. Salisbury Street</u>													
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Gruber</u> Last <u>Conley</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9 1879</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pinesburg Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Gruber</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Brubaker</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Virginia Bowser</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>A.C. Myocardial Infarction due to</u> Conditions, if any, which gave rise to immediate cause (b) <u>INTERVAL BETWEEN ONSET AND DEATH</u> (a), stating the underlying cause last. (c) <u></u> DUE TO <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <u>a.m.</u> <u>19</u> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/17/61</u> to <u>7/17/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/17/61</u> , 19 <u>61</u> , and that death occurred <u>3A</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Robert L. Young</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>7/18/61</u>					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 20 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 19 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

1942

1942

THE
OFFICE OF THE
DIRECTOR
OF THE
BUREAU OF
THE
FEDERAL
BUREAU OF
INVESTIGATION
WASHINGTON, D. C.

TO THE DIRECTOR

FROM THE
SPECIAL AGENT
IN CHARGE
OF THE
BUREAU OF
THE
FEDERAL
BUREAU OF
INVESTIGATION
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8499 CERTIFICATE OF DEATH 08493											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				d. STREET ADDRESS <u>755 S. Potomac St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>mamie Viola Cross</u>						4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1895</u>		9. AGE (In years last birthday) <u>66 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Funkstown, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles House</u>						14. MOTHER'S MAIDEN NAME <u>Susan Bagent</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-09-6564</u>		17. INFORMANT <u>James M. Cross</u> Address <u>539 N. Locust St. Hagerstown, Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> 157X } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CARCINOMA OF THE PANCREAS</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u> <u>10 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>April 12, 1961</u> to <u>July 11, 1961</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>July 11, 1961</u> , and that death occurred at <u>7:55 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Antonio U. Pallagrosi</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>July 11, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>						22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 13, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Hork</u>						ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(M)

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Washington

Washington

Life

Washington

777 2nd Avenue St.

Washington State Hospital

Washington State Hospital

Seattle, Wash.

Washington

Washington

(I)

Charles Jones

Charles Jones

24-1-1951 Charles Jones 777 2nd Avenue St. Washington, D.C.

Washington State Hospital

July 12, 1951

July 11, 1951

Washington State Hospital

July 12, 1951 Washington State Hospital

Washington State Hospital

Washington State Hospital

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8500

08494

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 18 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 702 Guilford Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 702 Guilford Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Bertram Davis First Middle Last S. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of Car Equipment 10b. KIND OF BUSINESS OR INDUSTRY Railroad		4. DATE OF DEATH Month July Day 12 Year 19 61 9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY? Baltimore, Md.	
13. FATHER'S NAME Alfred Davis		14. MOTHER'S MAIDEN NAME Elma Van Buskirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-6426	
17. INFORMANT Address Mrs. Sarah Russell Davis Hag. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous myocardial infarction 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>30 July, 1957</u> to <u>late</u> 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>16 June 1961</u>, and that death occurred on <u>11:30 AM</u>, from the causes and on the date stated above. 22a. SIGNATURE Richard T. Binford 22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D. 22d. ADDRESS 1135 POTOMAC AVENUE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 15, 1961	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUL 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
8501														
08495														
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport R # 1					c. LENGTH OF STAY IN 1b 72 Yrs					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Williamsport R # 1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dellinger Road					d. STREET ADDRESS Dellinger Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM ROMAN DELLINGER					4. DATE OF DEATH July 30 1961					5. SEX Male				
6. COLOR OR RACE White					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Dec 26 1888				
9. AGE (In years last birthday) 72 yrs.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer					11. BIRTHPLACE (County & State, or foreign country) Williamsport Wash Co Md. USA				
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME William H. Dellinger					14. MOTHER'S MAIDEN NAME Mary Slifer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W.#1					16. SOCIAL SECURITY NO. 215-36-6635					17. INFORMANT Mrs Ruth S. Dellinger Williamsport Md. R # 1				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 3-1-1961, to 7-30-1961, that (I) (we) last saw the deceased alive on 7-29-1961, and that death occurred at 4 AM, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8/2/61 23c. NAME OF CEMETERY OR CREMATORY River View cemetery 23d. LOCATION (City, town or county) (State) Williamsport Wash Co Md. 24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman 25a. REC'D BY REGISTRAR AUG 3 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines														

(M)

Washington

Department

Secretary

Mr. [Name]

Dear Sir:

Very much

pleased

to

hear

from

you

and

hope

you

will

continue

to

write

me

soon

Very

truly

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friend

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Andrew H. Colman, Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8502

CERTIFICATE OF DEATH

08496

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 Norway Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Susan Katherine Derr		4. DATE OF DEATH Month Day Year July 20, 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 10, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Kneisley		14. MOTHER'S MAIDEN NAME Adaline Cover	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Mrs. Katherine Klinkhart, Hagerstown, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1959 to July 20, 1961 that (I) (we) last saw the deceased alive on 6:30 AM 19 61 and that death occurred at 6:30 AM from the cause and on the date stated above.			
22a. SIGNATURE John D. Turco		22b. DATE SIGNED 7-21-61	
22c. PHYSICIAN'S NAME (Type) Dr. John D. Turco		22d. ADDRESS 302 N. Potomac St-Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7-22-61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUL 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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8503
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08497

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna First Elizabeth Middle Eichelberger Last		4. DATE OF DEATH Month July Day 16 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Milton Kershner		14. MOTHER'S MAIDEN NAME Mary E. Cearfoss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Hilda Barnes Chambersburg, Pa.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobes pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) general arteriosclerosis + cerebral thrombosis, senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 24, 1961 to July 16, 1961 , that (I) (we) last saw the deceased alive on July 15, 1961 , and that death occurred at 3:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III		22b. DATE SIGNED 7/17/61	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22d. ADDRESS 217 West Washington St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-9-61	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott T. Minnich		25a. REC'D BY REGISTRAR JUL 20 '61	
ADDRESS Son Hagerstown, md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G290 7/14/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 08498

8504

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>12 hours</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>103 Franklin St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CORA ELLEN EVERSOLE</u> First Middle Last				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1885</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mid Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Fulton County Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME <u>Henry Robinette</u>				14. MOTHER'S MAIDEN NAME <u>Jane E Beatty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Joseph Montgomery</u> Address <u>Hancock Md.</u> <u>103 Franklin St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MESENTERIC THROMBOSIS with gangrene of intestine</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>48 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 6, 1961</u> , to <u>July 7, 1961</u> , that I last saw the deceased alive on <u>July 6, 1961</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>7/7/61</u> ACTUAL SIGNATURE <u>J. H. Kehne</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>J. H. Kehne, M. D. 131 W. Washington St. Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7.10.61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Buck Valley Christian</u>		22d. LOCATION (City, town, or county) (State) <u>Buck Valley Fulton Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Howard Hancock Md.</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		1880		Maryland		Farmer		Married		White	
9. PLACE OF DEATH		10. CAUSE OF DEATH		11. PERIOD OF ILLNESS		12. TIME OF DEATH		13. PLACE OF BURIAL		14. NAME OF FUNERAL HOME		15. NAME OF MINISTER		16. NAME OF CLERGYMAN	
Home		Heart Disease		2 weeks		10:00 AM		Catholic Cemetery		St. Mary's		Rev. J. H. Smith		Rev. J. H. Smith	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CLERGYMAN		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF MINISTER		23. SIGNATURE OF CLERGYMAN		24. SIGNATURE OF CLERGYMAN	
25. NAME OF DECEASED		26. SEX		27. AGE		28. DATE OF BIRTH		29. PLACE OF BIRTH		30. OCCUPATION		31. MARITAL STATUS		32. COLOR	
33. PLACE OF DEATH		34. CAUSE OF DEATH		35. PERIOD OF ILLNESS		36. TIME OF DEATH		37. PLACE OF BURIAL		38. NAME OF FUNERAL HOME		39. NAME OF MINISTER		40. NAME OF CLERGYMAN	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESSES		43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF CLERGYMAN		45. SIGNATURE OF FUNERAL HOME		46. SIGNATURE OF MINISTER		47. SIGNATURE OF CLERGYMAN		48. SIGNATURE OF CLERGYMAN	
49. NAME OF DECEASED		50. SEX		51. AGE		52. DATE OF BIRTH		53. PLACE OF BIRTH		54. OCCUPATION		55. MARITAL STATUS		56. COLOR	
57. PLACE OF DEATH		58. CAUSE OF DEATH		59. PERIOD OF ILLNESS		60. TIME OF DEATH		61. PLACE OF BURIAL		62. NAME OF FUNERAL HOME		63. NAME OF MINISTER		64. NAME OF CLERGYMAN	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF WITNESSES		67. SIGNATURE OF PHYSICIAN		68. SIGNATURE OF CLERGYMAN		69. SIGNATURE OF FUNERAL HOME		70. SIGNATURE OF MINISTER		71. SIGNATURE OF CLERGYMAN		72. SIGNATURE OF CLERGYMAN	
73. NAME OF DECEASED		74. SEX		75. AGE		76. DATE OF BIRTH		77. PLACE OF BIRTH		78. OCCUPATION		79. MARITAL STATUS		80. COLOR	
81. PLACE OF DEATH		82. CAUSE OF DEATH		83. PERIOD OF ILLNESS		84. TIME OF DEATH		85. PLACE OF BURIAL		86. NAME OF FUNERAL HOME		87. NAME OF MINISTER		88. NAME OF CLERGYMAN	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF WITNESSES		91. SIGNATURE OF PHYSICIAN		92. SIGNATURE OF CLERGYMAN		93. SIGNATURE OF FUNERAL HOME		94. SIGNATURE OF MINISTER		95. SIGNATURE OF CLERGYMAN		96. SIGNATURE OF CLERGYMAN	
97. NAME OF DECEASED		98. SEX		99. AGE		100. DATE OF BIRTH		101. PLACE OF BIRTH		102. OCCUPATION		103. MARITAL STATUS		104. COLOR	
105. PLACE OF DEATH		106. CAUSE OF DEATH		107. PERIOD OF ILLNESS		108. TIME OF DEATH		109. PLACE OF BURIAL		110. NAME OF FUNERAL HOME		111. NAME OF MINISTER		112. NAME OF CLERGYMAN	
113. SIGNATURE OF DECEASED		114. SIGNATURE OF WITNESSES		115. SIGNATURE OF PHYSICIAN		116. SIGNATURE OF CLERGYMAN		117. SIGNATURE OF FUNERAL HOME		118. SIGNATURE OF MINISTER		119. SIGNATURE OF CLERGYMAN		120. SIGNATURE OF CLERGYMAN	

(M)

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This certificate is valid only when filed with the proper authorities.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8505
CERTIFICATE OF DEATH
08493

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown RFD c. LENGTH OF STAY IN 1b 3 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Gateway Conv Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Funkstown d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELI WILLIAM FAHRNEY		4. DATE OF DEATH Month Day Year July 9 1961 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not 5 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (in years last birthday) 90 yrs.
11. BIRTHPLACE (County & State, or foreign country) Funkstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah Fahrney		14. MOTHER'S MAIDEN NAME Cornida Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No ---		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Genevieve Shrader 23 E. Wash St		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Arterial Sclerosis DUE TO Fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left hip		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor May 10, 1961	
20c. TIME OF INJURY Month, Day, Year Hour a.m. May 10, 1961 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home		20f. (City or town) (County) (State) Hagerstown Wash Md.	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1961 to July 9, 1961, that (I) (we) last saw the deceased alive on July 8, 1961, and that death occurred at 9:55 PM from the causes and on the date stated above.			
22a. SIGNATURE David R. Brewer M.D.		22b. DATE SIGNED 7/10/61	
22c. PHYSICIAN'S NAME (Type) David R. Brewer		22d. ADDRESS Clear Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/11/61	
23c. NAME OF CEMETERY OR CREMATORY Funkstown cemetery		23d. LOCATION (City, town or county) (State) Funkstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		25a. REC'D BY REGISTRAR DATE JUL 12 '61	
		25b. REGISTRAR'S SIGNATURE Charles L. Finner	

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Handwritten notes and signatures, including "David A. Dresser" and "1948".

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8506

08500

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>45 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>16 Summer St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fred</u> <u>Levern</u> <u>Fales Sr.</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>19</u> <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2</u> <u>May 16, 1884</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance agent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Life Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ord, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Zacariah Fales</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Powers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-2219</u>		17. INFORMANT Address <u>Mr. Milo C. Fales 1108 Sunnyside Dr. Hagerstown, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage of middle cerebral artery</u> 331X DUE TO (b) <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerotic heart disease</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>14 July, 1961</u> to <u>19 July, 1961</u> , that (I) (we) last saw the deceased alive on <u>18 July, 1961</u> , and that death occurred at <u>25 AM</u> from the cause and on the date stated above.									
22a. SIGNATURE <u>Edwin H. Hoachlander</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Edwin H. Hoachlander</u>				22d. ADDRESS <u>Hager, Lew - md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 22, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown</u> <u>Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08501
75X-3

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>26 N. Carlisle St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Julia F. Fletcher</u>				4. DATE OF DEATH <u>July 10 1961</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 29 1885</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTH PLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harry A. Frary</u>				14. MOTHER'S MAIDEN NAME <u>Julia Starwood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harold W. Fletcher Jr.</u> Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery thrombosis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>8 wks.</u> <u>20 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) was attended the deceased from <u>9-1-39</u> 19 to <u>7-10-61</u> 19, that (I) was last saw the deceased alive on <u>7-10-61</u> 19, and that death occurred at <u>5:45 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W.C. Brewer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-10-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Brewer, M.D.</u>				22d. ADDRESS <u>Greencastle, Pennsylvania</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 12, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Co. Penna</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold W. Zimmerman</u>				ADDRESS <u>Hagerstown, Md.</u>		25. REC'D BY REGISTRAR <u>Jul 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>							

CERTIFICATE OF DEATH

1907

(M)

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CHIEF OF BUREAU

RECORDS SECTION

GENERAL INVESTIGATION

DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

SEPTEMBER 10, 1907

TO THE CHIEF OF BUREAU

FROM THE RECORDS SECTION

RE: [illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **08502**

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Kaetzel Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle DAVID Last FOUCH		4. DATE OF DEATH Month July Day 16 , Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1882
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Refractory Plant	
11. BIRTHPLACE (State or foreign country) Yarrowsburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN J. FOUCH		14. MOTHER'S MAIDEN NAME SARAH WEST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 236-03-8917	
17. INFORMANT Mrs. Jeanette M. Fouch		Address Knoxville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Posterior myocardial infarction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1961 , to July 16, 1961 , that I last saw the deceased alive on July 14, 1961 , and that death occurred at 8:50 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin B. Moody		ADDRESS (Street, city or town, state) 145 South Prospect Street, Hagerstown, Maryland	
DATE SIGNED 7/16/61			
PHYSICIAN'S NAME (Type) Edwin B. Moody		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/61	
22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		22d. LOCATION (City, town, or county) (State) Brownsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Donald C. Cables		24a. REC'D BY REGISTRAR DATE JUL 18 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

NAME OF DECEASED GEORGE DAVID KROUCH		SEX Male	
DATE OF BIRTH July 27, 1882		PLACE OF BIRTH Baltimore, Md.	
PLACE OF DEATH Washington Lourdes Hospital		CAUSE OF DEATH (To be filled by physician)	
DATE OF DEATH July 10, 1934		TIME OF DEATH 11:00 AM	
SIGNATURE OF PHYSICIAN (To be filled by physician)		SIGNATURE OF REGISTRAR (To be filled by registrar)	
SIGNATURE OF DECEASED (To be filled by deceased)		SIGNATURE OF WITNESSES (To be filled by witnesses)	
SIGNATURE OF NEAREST RELATIVE (To be filled by nearest relative)		SIGNATURE OF CLERK (To be filled by clerk)	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08503

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				d. STREET ADDRESS 624 W. Franklin St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jenny Middle Mae Last Fouche				4. DATE OF DEATH Month 7 Day 22 Year 19 61			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1890		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Road Side, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis E. Hovis				14. MOTHER'S MAIDEN NAME Esther Della			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-24-1609		17. INFORMANT R. W. Fouche Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture Rt Tibia DUE TO (c) 1th.						INTERVAL BETWEEN ONSET AND DEATH 1th.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while standing on sidewalk.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. July 15 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown W.	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1961 to July 22, 1961 , that (I) (we) last saw the deceased alive on July 22, 1961 , and that death occurred at 1:30 PM from the causes and on the date stated above.							
22a. SIGNATURE J H Beachley M.D.				22b. DATE SIGNED July 22, 1961			
22c. PHYSICIAN'S NAME (Type) J H Beachley				22d. ADDRESS Hagerstown W.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7-26-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kraiss Funeral Home				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUL 27 '61	
				25b. REGISTRAR'S SIGNATURE Robert L. Farris			

5020

CERTIFICATE OF DEATH

5020

(M)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

AGE

PLACE OF DEATH

DATE OF BIRTH

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CAUSE OF DEATH

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PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8510

08504

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HANCOCK c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 122 FAIRVIEW DRIVE				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HANCOCK d. STREET ADDRESS 122 FAIRVIEW DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS ANDERSON FRANCIS				4. DATE OF DEATH Month 7 Day 19 Year 1961			
5. SEX MALE	6. COLOR OR RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/1880	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 7 Days 19	IF UNDER 24 HRS. Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BEAVER CREEK, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NOT KNOWN				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MARY BRUMBACK Address HANCOCK, MD. 122 FAIRVIEW DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 334X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerosis - generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs 20 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 26 , 19 59 , to July 17 , 19 61 , that (I) (we) last saw the deceased alive on July 17 , 19 61 , and that death occurred at 1:30 P. M., from the causes and on the date stated above.							
22a. SIGNATURE FB Thomas III M.D.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7-22-61	
22c. PHYSICIAN'S NAME (Type or print) F. D. THOMAS III M.D.		22d. ADDRESS HANCOCK, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/22/61	23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY		23d. LOCATION (City, town or county) (State) HANCOCK, MARYLAND			
24 FUNERAL DIRECTOR'S SIGNATURE Howard F. Stone		ADDRESS Hancock md		25a. REC'D BY REGISTRAR DATE JUL 25 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Farris		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1

Howard H. Kane Kansas City

[Faint, mostly illegible handwritten text, possibly a letter or document, with some words like "Kansas" and "City" visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8511

CERTIFICATE OF DEATH

08505

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 235 E. Irvin Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GEORGE Middle OTTERBEIN Last FUNKHOUSER			4. DATE OF DEATH Month July Day 13 Year 19 61		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH February 22, 1907		9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1	
11. IF UNDER 24 HRS. Hours 1 Min. 1		12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME George Snapp Funkhouser	
14. MOTHER'S MAIDEN NAME Edith H. Snapp		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-03-0140	
17. INFORMANT Mrs. Garnetta Funkhouser Hagerstown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung with metastases 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from Dec. 11-12-18A. 59 to July 13 19 61 that I (we) last saw the deceased alive on July 12 19 61 and that death occurred at M , from the causes and on the date stated above.					
22a. SIGNATURE B. B. Kneisley M.D.		22b. DATE SIGNED 7/14/61		22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.	
22d. ADDRESS 148 West Washington Street Hagerstown, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 7/15/1961		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouner Funeral Home R. Franklin Ringer		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR JUL 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
8512														
CERTIFICATE OF DEATH														
08506														
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 6 Mos d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1416 Potomac Ave						2. USUAL RESIDENCE (Where deceased lived, if institution; Residencia before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 405 West Franklin St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) ROSE (NMN) GALLO						4. DATE OF DEATH July 2 1961 19								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 24 1887 74 yrs.		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Rovita Italy				12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Antonio Lettiere						14. MOTHER'S MAIDEN NAME Louise (unknown)								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Rose White 1416 Potomac Ave Hagerstown Md. Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial infarction DUE TO (c) Coronary arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 5 hr 18 hr Unk														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that (I) (this hospital) attended the deceased from March 4, 1928 to July 2, 1961 , that (I) (we) last saw the deceased alive on July 2, 1961 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.														
22a. SIGNATURE [Signature]						22b. DATE SIGNED 7/3/61			22c. NAME (Type) [Signature]			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/5/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman						25a. REC'D BY REGISTRAR JUL 6 '61			25b. REGISTRAR'S SIGNATURE [Signature]			25c. ADDRESS Hagerstown Md.		

VR A15 (4)
15M 9/60

17500

CONTINUED

3513

(M)

(1)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "January" and "February" are faintly visible.]

Wm. H. Hays

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8513

CERTIFICATE OF DEATH

08507

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>20 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1933 Armstrong Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JAMES BRENT GLESNER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2 1889</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oil Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W Va Martinsburg Berkley Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jacob F. Glesner</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McLaughlin</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>W.W.# 1 334-01-6192</u>		17. INFORMANT <u>Mrs Hazel Glesner 923 Armstrong Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Generalized Atherosclerosis Syks</u> DUE TO (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-27</u> 19<u>61</u> to <u>7-28</u> 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>7-28-61</u>, and that death occurred at <u>9:45</u> a.m. from the causes and on the date stated above.									
22a. SIGNATURE <u>ME Byrkit</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-31-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>ME Byrkit</u>				22d. ADDRESS <u>Williamsport Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) <u>Hagerstown Wash Co Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 3 '61</u>			
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>			

VR A15 (4)
15M 9/60

200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DRISHEAL

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
WASHINGTON				MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY		WASHINGTON	
TREGO - RURAL		66 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		TREGO - RURAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
KEEDYSVILLE MD. R.I				KEEDYSVILLE MD. R.I			
a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
HARRY MILTON GLOSS				JULY 23 - 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		JUNE -14-1879	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
82 yrs.		FARMER		OWN FARM.		ANTIETAM WASH. Co. MD. U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE W. GLOSS				MALINDA KEEDY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
NO				NONE			
17. INFORMANT				Address			
MASS MAUDE GLOSS				KEEDYSVILLE MD. R.I			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Cerebral arteriosclerosis			
234X DUE TO				Generalized arteriosclerosis.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 6, 1961 to July 23, 1961, that (I) (we) last saw the deceased alive on July 15, 1961, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
Walter H. Shealy M. D.				7/24/61.			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
Walter H. Shealy M. D.				Sharpsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
BURIAL				JULY 26 1961			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
ROHRERSVILLE CEMETERY				ROHRERSVILLE WASH. Co. MD.			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
John D. East				DATE JUL 28 '61			
BOONSBORO MD.				25b. REGISTRAR'S SIGNATURE			
				Arthur L. Kline			

M
JAN 10 1917

3134

WASHINGTON

Maryland

TRUSS - 1874 - 1875

REEDSVILLE MD R

HARRY DUNTON

MALE WHITE

JUNE 14 - 1872

FARMER

GEORGE W. CROSS

NO

Cerebral arteriosclerosis

Generalized arteriosclerosis.

July 15 61 July 6 July 28 61

7/24/61

Walter L. Sheely M. D.

Sheepsville, Md.

July 24 - 1917
JAN 10 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
8515									
08509									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 18 Dunn Irvin Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First David Middle William Last Gossard					4. DATE OF DEATH Month July Day 19 Year 1961				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH July 19, 1961				
9. AGE (In years last birthday) yrs. 15					10. IF UNDER 1 YEAR Months 15 Days 15 Min. 15				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none					10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Maryland				
11. BIRTHPLACE (County & State, or foreign country) U.S.A.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William S. Gossard					14. MOTHER'S MAIDEN NAME Kathleen E. Schleigh				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none				
17. INFORMANT William S. Gossard					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 762.5 atelectasis Conditions, if any, which gave rise to immediate cause (b) streptococci (a), stating the underlying cause last. (c) 9 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Birth									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 7/19, 1961 to 7/19, 1961 that (I) (we) last saw the deceased alive on 7/19, 1961 , and that death occurred at 3:58 PM from the causes and on the date stated above.									
22a. SIGNATURE [Signature] M.D. 7/20/61									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) HARRY D. BOWMAN, MD									
22d. ADDRESS 318 N. POTOMAC ST. HAGERSTOWN									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 7/20/1961									
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery									
23d. LOCATION (City, town or county) (State) Hagerstown, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE Suter & Rouzer Funeral Home R. Franklin Rizer ADDRESS Hagerstown, Md.									
25a. REC'D BY REGISTRAR JUL 24 '61									
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

2081212XV1

2012

Washington

Washington

Washington County, Oregon

David

William

George

only

12

12

White

July 12, 1911

12

none

Washington, D.C.

William S. Brown

William S. Brown

no

none

William S. Brown

Washington, D.C.

Washington, D.C.

7/20/1911

White

Washington, D.C.

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8516

CERTIFICATE OF DEATH

Reg. Dist. No.

08510

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dargan	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS RFD#1, Harpers Ferry, W. Va.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEONA Middle CATHERINE Last GRIM		4. DATE OF DEATH Month July Day 6 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1922
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietician		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Rohrersville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Flook		14. MOTHER'S MAIDEN NAME Katie Haines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 215-34-3511	
17. INFORMANT Mr. Weller Grim Address RFD # 1, Harpers Ferry, West Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 171X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis L Kidney		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 59 , to July 6 , 19 61 , that I last saw the deceased alive on July 5 , 19 61 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE S F Waddell		ADDRESS (Street, city or town, state) DATE SIGNED 115 King St. Hagerstown, Md. 7-6-61	
PHYSICIAN'S NAME (Type) Samuel F. Waddell		115 King St. Hagerstown, Md. 7-6-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/9/61	
22c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		22d. LOCATION (City, town, or county) (State) Samples Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold Cackle		ADDRESS Harpers Ferry, W. Va.	
24a. REC'D BY REGISTRAR DATE JUL 17 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9 & 14 Filed G292 8/8/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 08511

1. PLACE OF DEATH a. COUNTY Washington, Ft Ritchie, Cascade MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Ritchie, Md.		c. LENGTH OF STAY IN 1b Fort Ritchie, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY DISPENSARY, FT RITCHIE, MD.		d. STREET ADDRESS Bldg. 451 Apt. #5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES First LAIRD Middle HANNEN Last		4. DATE OF DEATH Month July Day 31 Year 19 61	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Oct 1919
9. AGE (In years last birthday) 41 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Specialist		10b. KIND OF BUSINESS OR INDUSTRY US ARMY	
11. BIRTHPLACE (State or foreign country) Cliftonville, W. Va.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME CHARLES HANNEN		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1295-10-5177	
17. INFORMANT From Army Records by WILLIAM T CUZICK Capt, MSC		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) None DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20-25min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 28 July , 19 61 , and that death occurred at 0510AM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Fort Ritchie, Cascade, Maryland 31 Jul 61			
ACTUAL SIGNATURE <i>Patrick J Ferraro</i>		M.D. Fort Ritchie, Cascade, Maryland	
PHYSICIAN'S NAME (Type) PATRICK J FERRARO, CAPT., MC		Fort Ritchie, Md. US ARMY DISPENSARY	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/1961	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Steubenville, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. Marlin Poe</i>		ADDRESS Waynesboro, Penna.	
24a. REC'D BY REGISTRAR DATE AUG 3 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8518

08512

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owensville</u> d. STREET ADDRESS <u>02X-2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur ELLsworth Hardesty</u> First Middle Last 4. DATE OF DEATH <u>7</u> Month <u>31</u> Day <u>19</u> Year <u>61</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 3, 1878</u> 9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> IF UNDER 24 HRS. Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Ret.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Tabacca</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Richard H. Hardesty</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Faust</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Mr Andrew Sothoron-118 9th St. N.E. Washington, D.C.</u> Address <u>Washington, D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin's disease</u> DUE TO (b) <u>201X</u> Conditions, if any, which gave rise to immediate cause (c) <u>17 months</u> DUE TO (e), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour e.m. <u>10:15</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>April 24, 1961 to July 31, 1961</u> 20g. (County) <u>Calvert County, Maryland</u> 20h. (State) <u>Md.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>April 24, 1961</u> to <u>July 31, 1961</u> , that (I) <u>was</u> last saw the deceased alive on <u>July 31, 1961</u> , and that death occurred at <u>10:15</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>Young E. Chun</u> 22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22b. DATE SIGNED <u>July 31, 1961</u> 22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>August 2, 61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Harmony Cemetery</u> 23d. LOCATION (City, town or county) <u>Calvert County, Maryland</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchons Funeral Home</u> ADDRESS <u>Owings, Maryland</u> 25a. REC'D BY REGISTRAR <u>AUG 3 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

0340

0340

Time 10:00

Location

Remarks

Remarks

Water level 100 ft

X

100 ft

100 ft

100 ft

X

100 ft

100 ft

100 ft

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100 ft

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100 ft

M

1

MADE IN U.S.A.
20X COLTON

2213

CENTRATIVE OF DEATH

158 W. Los Angeles St.

Los Angeles, Cal.

June 15, 1941

July 3, 1941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08514

8520

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1b 3 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) FORNITT KEEDY MEM. HOME		d. STREET ADDRESS 1 W. WASHINGTON ST. EXT.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET ELLEN HIXON		4. DATE OF DEATH Month Day Year JULY 5 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1884
9. AGE (In years last birthday) 77 rs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. ZULLINGER		14. MOTHER'S MAIDEN NAME ELLEN JANE RISE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. RAYMOND Z. HIXON		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension - Cardiac - Vascular DUE TO Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 2, 1961 , to July 5, 1961 , that I last saw the deceased alive on July 5, 1961 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Hixon M.D.		ADDRESS (Street, city or town, state) Baltimore Md.	
DATE SIGNED 7/6/61			
PHYSICIAN'S NAME (Type) G. W. Hixon			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/8/61	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR JUL 10 '61		24b. REGISTRAR'S SIGNATURE Arthur E. Hixon	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

(Faint, mostly illegible text from the reverse side of the document is visible through the paper. The form includes fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Place of Death. There are also sections for the attending physician and the funeral home. The text is mirrored from the back of the page.)

(Handwritten signature and text at the bottom of the page, likely from the funeral home or physician.)

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8521

CERTIFICATE OF DEATH

08515

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Hagerstown d. STREET ADDRESS Route 4 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Elmer Hoffman		4. DATE OF DEATH Month July Day 27 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1915
9. AGE (In years last birthday) 45 yrs.		10. BIRTHPLACE (County & State, or foreign country) Mt. Savage, Md.	
11. BIRTHPLACE (County & State, or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Elmer Hoffman		14. MOTHER'S MAIDEN NAME Carrie Hyde	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Jane Hoffman	
17. INFORMANT Mrs. Jane Hoffman		Address Rt. 4 Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330 X Subarachnoid Hemorrhage Consequence of malformation of blood vessels in brain Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 330 X DUE TO (c) Rheumatoid arthritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Rheumatoid arthritis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 9 days	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 24, 1961, to July 27, 1961, that (I) (we) last saw the deceased alive on July 27, 1961, and that death occurred at 12:26 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. DATE SIGNED 7/28/61	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-30-61	
23c. NAME OF CEMETERY OR CREMATORY Long Meadow Cemetery		23d. LOCATION (City, town or county) (State) Paramount Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25. REC'D BY REGISTRAR JUL 31 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8522

CERTIFICATE OF DEATH

Reg. Dist. No. 08516

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mercersburg, Penna.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Conv. Home		d. STREET ADDRESS 131 W. Seminary St. 75x3	
3. NAME OF DECEASED (Type or print) First EDWIN Middle Last HOFFMAN		4. DATE OF DEATH Month July Day 1, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/1880
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Businessman		10b. KIND OF BUSINESS OR INDUSTRY Investments	
11. BIRTHPLACE (State or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB HOFFMAN		14. MOTHER'S MAIDEN NAME ISABELLA EVANS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Edwin Hoffman		Address Mercersburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 mo +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 June 1961, to 1 July 1961, that I last saw the deceased alive on 29 June 1961, and that death occurred at 10:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE F. F. Lusby		DATE SIGNED 3 July 61	
PHYSICIAN'S NAME (Type) F. F. Lusby		M.D. 230 N. Colony St. Hagerstown Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/61	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cem.		22d. LOCATION (City, town, or county) (State) Mercersburg, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. M. Lutzinger		ADDRESS Mercersburg, Pa.	
24a. REC'D BY REGISTRAR DATE JUL 5 '61		24b. REGISTRAR'S SIGNATURE C. S. S. Hume	

TO BE RETURNED TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETURNED TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 1

VR A15 (4)
15M 9/59

8523

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08517

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 19 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EMMETT Last IRWIN		4. DATE OF DEATH Month 7 Day 1 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 10, 1888
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MOLLER ORGAN WORKS	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY H. IRWIN		14. MOTHER'S MAIDEN NAME EMMA SUPINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1910-1914 220-16-0669	
17. INFORMANT MRS. PAULINE IRWIN		Address 1054 S. POTOMAC AT. HAGERSTOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertensive Cardio-Vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 MIN.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1961 to July 1, 1961 , that (I) (we) last saw the deceased alive on July 119 61 , and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. John D. Turco		22b. DATE SIGNED 7-3-61	
22c. PHYSICIAN'S NAME (Type) Dr. John D. Turco		22d. ADDRESS 302 N. Potomac Street-Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/5/1961	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL		23d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE KRAISS FUNERAL HOME		25a. REC'D BY REGISTRAR JUL 7 '61	
ADDRESS HAGERSTOWN, MD.		25b. REGISTRAR'S SIGNATURE William L. Kraiss	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08518

8524

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>207 N. Mulberry St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nora</u> <u>Rose</u> <u>Kipe</u>		4. DATE OF DEATH Month Day Year <u>July</u> <u>13</u> <u>19 61</u>		5. SEX <u>Female</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1896</u>			
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sabina, Ohio</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>No Record</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give number or date of service) <u>None</u>		17. INFORMANT Address <u>Mr. Lewis Kipe 207 N. Mulberry St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Partial Intestinal Obstruction</u> DUE TO (b) <u>Intra-abdominal Metastasis from Epidermoid Carcinoma of the Cervix</u> DUE TO (c) <u>Severe generalized osteoarthritis (Epidermoid carcinoma of cervix grade III treated July 1954)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe generalized osteoarthritis (Epidermoid carcinoma of cervix grade III treated July 1954)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19 61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>June 14, 19 61 to July 13, 19 61</u>			
20f. (City or town) <u>Hagerstown</u>		20g. (County) <u>Washington</u>		20h. (State) <u>Maryland</u>			
21. I certify that (I) XXXXXX attended the deceased from <u>June 14, 19 61 to July 13, 19 61</u>, that (I) was saw the deceased alive on <u>July 13, 19 61</u>, and that death occurred at <u>3:15 pm</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. T. Layman, M.D.</u>		22b. DATE SIGNED <u>7-14-61</u>		22c. PHYSICIAN'S NAME (Type) <u>W. T. Layman, M.D.</u>			
22d. ADDRESS <u>100 Professional Arts Bldg. Hagerstown, Maryland</u>		23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>July 15, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> <u>Wm. A. Horst</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

M

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1824

Washington County Hospital

307 A. Highway 24

Home, wife, and child

Home, wife, and child

No record

No record

Home, wife, and child

Home, wife, and child

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
8525											
08519											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital						d. STREET ADDRESS 70 Walnut					
3. NAME OF DECEASED (Type or print) First JOHN Middle Hetzel Last KLINE						4. DATE OF DEATH Month JULY Day 6 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 7, 1901		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Kline						14. MOTHER'S MAIDEN NAME Sarah Saville					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-16-3764		17. INFORMANT Mrs. Ray Guy				Address Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL LOBULAR PNEUMONIA 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE-UNKNOWN (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) SEROFIBRINOUS PERICARDITIS										INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Westernport		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-26-61 , to 7-6-61 , that (I) (was) last saw the deceased alive on 7-6-61 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Antonio U. Pallagrosi M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI						22d. ADDRESS 1500 PENNA AVE HAGERSTOWN M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/10/61		23c. NAME OF CEMETERY OR CREMATORY Philos Cem		23d. LOCATION (City, town or county) Westernport		(State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE E.S. Boal						ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JUL 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

VR A15 (4)
15M 9/60

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1938

1938

Eastern Ill. State Hospital
Joliet, Ill.

John H. Hines
Joliet, Ill.

John Hines
Joliet, Ill.

John Hines
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John Hines
Joliet, Ill.

Western, Mo.

1938

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8528

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08520

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theresa Middle Marie Last Kline				4. DATE OF DEATH Month 7 Day 26 Year 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-26-61	
9. AGE (In years lost birthday) yrs. 3		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY infant		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Kline		14. MOTHER'S MAIDEN NAME Mary Warrenfeltz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Charles Kline Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Foetal Anemia DUE TO Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE John D. Turco				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-28-61	
22c. PHYSICIAN'S NAME (Type) Dr. John D. Turco				22d. ADDRESS 302 N. Potomac St-Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/28/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md	
24. FUNERAL DIRECTOR'S SIGNATURE Suter-Rogers Funeral Home				25a. REC'D BY REGISTRAR AUG 9 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 5/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8527

08521

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 2 WEEKS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 509 FURNACE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Klitsch Last Klitsch		4. DATE OF DEATH Month July Day 4 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 4, 1893
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 0 Days 10 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GOTTLIEB KLITSCH		14. MOTHER'S MAIDEN NAME WLIZABETH WIEGAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MARGARET A. DEAN		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia DOX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breast with metastasis to pleura and pericardium DUE TO (c) 6 years INTERVAL BETWEEN ONSET AND DEATH one week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 23, 1961 to July 5, 1961 , that (I) (we) last saw the deceased alive on July 5, 1961 , and that death occurred at 5:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED July 5, 1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS Western Maryland State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 7, 1961	
23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMETERY		23d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT		25a. REC'D BY REGISTRAR DATE JUL 10 '61	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8528

CERTIFICATE OF DEATH

08522

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Smithsburg R # 2</u>				c. LENGTH OF STAY IN 1b <u>85 Yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cavetown Pike</u>				d. STREET ADDRESS <u>Cavetown Pike</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA</u> <u>AMELIA</u> <u>KRETSINGER</u>				4. DATE OF DEATH Month Day Year <u>July 20 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 5 1875</u>	
9. AGE (In years last birthday) <u>85 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		9. AGE (In years last birthday) <u>85 yrs.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Chewsville Wash Co Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John W. Beard</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Baechtel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs Beulah Hoover Smithsburg R # 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (c) <u>20 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>20 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-16</u> , 19 <u>56</u> to <u>7-20</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-20</u> , 19 <u>61</u> , and that death occurred at <u>10:00 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. Hess</u>				22b. DATE SIGNED <u>7-21-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery Mausoleum</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				25a. REC'D BY REGISTRAR <u>JUL 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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Andrew K. Gifford, Washington, D.C.

March 24, 1954

Form 100

Enclosure

Very truly yours,

General

Dear Sir:

I am writing to you regarding the matter of the
the above mentioned subject. I have been
informed that you are interested in the
subject and I am sure that you will find
the information of interest.

The information is being furnished to you
for your information and for the use of
your office. It is not to be distributed
outside of your office without the
approval of the Bureau.

I am sure that you will find the
information of interest and I am sure
that you will find it of value.

I am sure that you will find the
information of interest and I am sure
that you will find it of value.

I am sure that you will find the
information of interest and I am sure
that you will find it of value.

I am sure that you will find the
information of interest and I am sure
that you will find it of value.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DR. HARRISON
318 N. POTOMAC ST.
081

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
8529											
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MHAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>8 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> d. STREET ADDRESS <u>BOONSBORO MD. R.2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>CLARENCE ALBERT LEGGETT</u>						4. DATE OF DEATH <u>JULY 17 1961</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 22-1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>BOONSBORO WASH. CO. MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM LEGGETT</u>						14. MOTHER'S MAIDEN NAME <u>SARAH PARKS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIS F. LEGGETT</u> Address <u>BOONSBORO MD. R.2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH 8 days</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 9 1961</u> to <u>July 17 1961</u> that (I) (we) last saw the deceased alive on <u>July 16 1961</u> and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Paul Harrison</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Paul Harrison</u>						22b. DATE SIGNED <u>7/18/61</u>					
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 19 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>				23d. LOCATION (City, town or county) <u>BOONSBORO WASH. CO. MD.</u> (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u>				ADDRESS <u>BOONSBORO MARYLAND</u>				25a. REC'D BY REGISTRAR <u>JUL 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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1945-1946

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1946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8530											
CERTIFICATE OF DEATH											
08524											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R. F. D. c. LENGTH OF STAY IN lb 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gateway Conv Home						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 208 No Potomac St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) SAMUEL LUTHER LUMM						4. DATE OF DEATH Month Day Year July 28 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 1 1876		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (County & State, or foreign country) Mt Lena Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther Lumm						14. MOTHER'S MAIDEN NAME Mary McKinzie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 220-09-7572		17. INFORMANT Address David R. Lumm 208 No Potomac St					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 DUE TO Acute Cardiac Failure Arterio Sclerotic Heart Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 15, 1961 to July 28, 1961 , that (I) (we) last saw the deceased alive on July 28, 1961 , and that death occurred at 7:59 A.M. from the causes and on the date stated above.											
22a. SIGNATURE David R. Brewer M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/30/61			
22c. PHYSICIAN'S NAME (Type) David R. Brewer						22d. ADDRESS Clear Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/31/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown Md.						25a. REC'D BY REGISTRAR DATE AUG 3 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



Andrew K. Coffman, Hagerstown, Md.

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Williamsport		c. LENGTH OF STAY IN lb unknown hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 309 S Montvallla Ave.	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Potomac River				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
	3. NAME OF DECEASED (Type or print) Norman		First Middle Last Wilbert Malott		4. DATE OF DEATH Month Day Year July 21 1961			
	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2 1922	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days 6 18	IF UNDER 24 HRS. Hours Min. 00 00	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY House Contractor		11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
	13. FATHER'S NAME Edward Malott				14. MOTHER'S MAIDEN NAME Letha Wiley			
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 14 6217		17. INFORMANT Mrs. Mary Louise Malott			
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Instant			
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Found floating in Potomac River.						
20c. TIME OF INJURY Month, Day, Year Hour p.m. 7-21- 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River		20f. (City or town) (County) (State) Williamsport, Washington, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 22, 1961				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24-61		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or country) (State) Williamsport Maryland		
23. FUNERAL DIRECTOR Ormel Burton		ADDRESS Williamsport, Md.		24a. REC'D BY REGISTRAR JUL 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

MEDICAL CERTIFICATION

21

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NO. 100
JULY 1941

Handwritten signature

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BP
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8532
CERTIFICATE OF DEATH
08526

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash County Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 704 No Mulberry St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) ANTHONY MARCONI		4. DATE OF DEATH July 28 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26 1961		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2		IF UNDER 24 HRS. Hours 2 Min.			
10a. USUAL OCCUPATION (Give time of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Infant				11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md.				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas Marconi				14. MOTHER'S MAIDEN NAME Jacklyn Gelwicks				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Thomas Marconi 704 No Mulberry St Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (28 wks) DUE TO (b) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from July 26 1961 to July 28 1961 , that (I) (we) last saw the deceased alive on July 28 1961 , and the death occurred at 7:28 M, from the causes and on the date stated above.												INTERVAL BETWEEN ONSET AND DEATH 2 days							
22a. SIGNATURE Paul Harrison				22b. DATE SIGNED 7-29-61				22c. PHYSICIAN'S NAME (Type) PAUL HARRISON, M. D.				22d. ADDRESS 518 N. POTOMAC ST., HAGERSTOWN, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/29/61				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				24b. ADDRESS Hagerstown Md.				25a. REC'D BY REGISTRAR AUG 3 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

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2882

2882

THE
OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK
ALBANY

IN SENATE
JANUARY 1, 1901

REPORT OF
THE
COMMISSIONER OF
THE
LAND OFFICE
FOR THE YEAR
1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8533

CERTIFICATE OF DEATH

08527

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 50 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSE Middle WILLIAM Last MARTIN		4. DATE OF DEATH Month JULY Day 14 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13 1891
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER		10b. KIND OF BUSINESS OR INDUSTRY MUNICIPAL EMP.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN J. MARTIN		14. MOTHER'S MAIDEN NAME ANNA C. FOUCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-096553	
17. INFORMANT MRS. MARGARET V. HOWLETT		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Immediate	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/14/61 19 to 7/14/61 19, that (I) (we) last saw the deceased alive on 7/14/61 19, and that death occurred at 10:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Young		22b. DATE SIGNED 7/16/61	
22c. PHYSICIAN'S NAME (Type) RALPH F. YOUNG		22d. ADDRESS Williamport, MD.	
23a. BURIAL, CREMATION, RITUAL (Specify) BURIAL		23b. DATE THEREOF 7/17/61	
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W.J. Hornum		25a. REC'D BY REGISTRAR DATE JUL 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

CERTIFICATE OF DEATH

2222

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8534

CERTIFICATE OF DEATH

08523

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
f. STREET ADDRESS 15 S. Maple Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Effie Middle May Last Masters		4. DATE OF DEATH Month July Day 18 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 4, 1869
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Greensburg, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Reynolds		14. MOTHER'S MAIDEN NAME Lydia Stephey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles D. Masters, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 20 yrs. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-26-60 19 60 to 7-17-61 19 61 , that (I) (we) last saw the deceased alive on 7-17-61 19 61 , and that death occurred at 10:10 a.m. M, from the causes and on the date stated above.			
22a. SIGNATURE Charles F. Hess		22b. DATE SIGNED 7-19-61	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M. D.		22d. ADDRESS Smithsburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7-21-61	
23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		25a. REC'D BY REGISTRAR DATE JUL 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

100-100000

(M)

TO : DIRECTOR, FBI (100-100000)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph memorandum or letter.]

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

081

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2

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY WASHINGTON				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VA.				b. COUNTY BERKELEY			
3. NAME OF DECEASED (Type or print) SALLY B. MILLS				4. DATE OF DEATH JULY 11 1961				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1915		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Breeden				14. MOTHER'S NAME Nora Breeden				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT James H. Mills (Husband)				Address 309 E. John St. Martinsburg, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL HEMATOMA, RIGHT PARIETAL MINIMAL DUE TO (b) SUBDURAL HEMATOMA, TEMPORAL & FRONTAL, OLD CEREBRAL EDEMA MODERATE DUE TO (c) PULMONARY EMBOLUS, LEFT FATTY CHANGE, LIVER								INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT RECENT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <i>E.W. Ditto, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7/12/61			
EXAMINER'S NAME (Type) E.W. DITTO, JR. M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Martinsburg Rt. # 1 (Berkeley County) W. Va.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-1961		22c. NAME OF CEMETERY OR CREMATORY Tuscarora Cemetery		22d. LOCATION (City, town, or country) Martinsburg Rt. # 1 (Berkeley County) W. Va.		23. FUNERAL DIRECTOR H.K. Brown ADDRESS Martinsburg, W. Va.			
24a. REC'D BY REGISTRAR JUL 14 '61				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

(M)

(1)

RIGHT PNEUMONIA, RIGHT PARIETAL PLEURAL
SUBCUTANEOUS, TEMPORAL & FRONTAL, CUT
CORNEAL EDEMA MODERATE
PULMONARY EMBOLUS, LEFT
FATTY CHANGE, LIVER

Howe, Sweden

William, Sweden

(Howe, Sweden)

John W. Howe

John W. Howe

7/12/61

7-1-1961, J.R.M.D.

(Howe, Sweden)

(Howe, Sweden)

7-1-1961

Howe, Sweden

Howe, Sweden

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08530

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROUTE 1, BIG SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROUTE 1, BIG SPRING, MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROUTE 1</u>			d. STREET ADDRESS <u>ROUTE 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>SARAH ANN MILLS</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>20</u> Year <u>19 61</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 20, 1872</u>		9. AGE (In years last birthday) <u>89</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME DUTIES</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAKE MANAN</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZEBETH MILLS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> <u>NONE</u> <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FRANK MILLS</u> Address <u>ROUTE 1, BIG SPRING, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7/21/61</u>	
EXAMINER'S NAME (Type) <u>J. E. W. Ditt.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 22, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARK HEAD CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>MARYLAND</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Rowland</u>		ADDRESS <u>CLEAR SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u>	

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HAWAII STATE DEPARTMENT OF HEALTH - BATHROOM 13

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is oriented horizontally but contains vertical text labels for various sections.

Vertical text labels on the right side of the form include:

- IDENTIFICATION
- PREVIOUS HISTORY
- PRESENT ILLNESS
- PHYSICAL EXAMINATION
- LABORATORY EXAMINATIONS
- DIAGNOSIS
- CAUSE OF DEATH
- REMARKS

The form contains numerous checkboxes and lines for handwritten notes. Some sections are partially obscured by a large, faint watermark or stamp in the center of the page.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8537

08531

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 35 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 478 Mitchell Ave.				d. STREET ADDRESS 478 Mitchell Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Virgil Middle George Last Montgomery				4. DATE OF DEATH Month July Day 3 Year 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 19, 1916		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cabinet maker		10b. KIND OF BUSINESS OR INDUSTRY organ factory		11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Montgomery				14. MOTHER'S MAIDEN NAME Nannie R. Wade			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 214-09-4502		17. INFORMANT Address Mrs. Lillian Montgomery, Hagerstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation (assumed) 412X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cardiac Hypertrophy Tricuspid Stenosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 15-30 minutes. 30 days certain	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (the hospital) attended the deceased from June 3 2:30 pm 1961 , that (I) (we) last saw the deceased alive on July 1 1961 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE <i>W. T. Layman</i>				22b. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland			
22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.				22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7-6-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JUL 7 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8538

08522

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MT. LENA - RURAL c. LENGTH OF STAY IN 1b 15 YEARS				2. USUAL RESIDENCE (Where deceased lived, if institutional residence, give institution name and address) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MT. LENA - RURAL d. STREET ADDRESS BOONSBORO MD. R.2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES E. MORGAN				4. DATE OF DEATH Month Day Year July 12 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 15 - 1871		9. AGE (In years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (County & State, or foreign country) TITLESTOWN WASH. CO. MD. U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME GEORGE MORGAN				14. MOTHER'S MAIDEN NAME NO RECORD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT HUBERT W. MORGAN		Address BOONSBORO MD. R.2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus & Hydronephrosis 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia - Secondary DUE TO (c) Prostatic Hypertrophy				INTERVAL BETWEEN ONSET AND DEATH Months Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Relat. Urinary Tract				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)					
21. I certify that (I) (this hospital) attended the deceased from May 5, 1961 to July 12, 1961 , that (I) (we) last saw the deceased alive on July 12, 1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE Philip J. Hirshman				M.D. Philip J. Hirshman		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/14/61	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.				22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 15, 1961		23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		23d. LOCATION (City, town or county) BOONSBORO WASH. CO. MD.		23e. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John H. East				ADDRESS BOONSBORO MD		25a. REC'D BY REGISTRAR DATE JUL 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DR. HIRSHMAN
159 W. WASH. ST.

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
85339
CERTIFICATE OF DEATH
08533

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				e. STREET ADDRESS 1810 W. Washington St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Pauline Middle Alice Last Myers				4. DATE OF DEATH Month 7 Day 27 Year 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1889	
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months 7 Days 27 Hours 19 Min. 61		IF UNDER 24 HRS. Months 7 Days 27 Hours 19 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Three Rivers, Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip M. Conner				14. MOTHER'S MAIDEN NAME Mary Heist			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Robert C. Myers		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 433.1 IMMEDIATE CAUSE (a) ventricular fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) arteriosclerosis Cardio vascular disease DUE TO (c) arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 weeks years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) lung fibrosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/15 19 60 to 7/27 19 61 that (I) (we) last saw the deceased alive on 7/27 19 61 , and that death occurred at 12 M. from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/28/61	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 N. Potomac St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7-30-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret R. Rowland				ADDRESS Clear Spring, Md.		25a. REC'D BY REGISTRAR DATE JUL 31 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8540 CERTIFICATE OF DEATH 08534											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 29 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital.,						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville., d. STREET ADDRESS 210 Lincoln Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary Jackson Palmer						4. DATE OF DEATH July 16, 1961					
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1897		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 4 Days 16 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME James E. Jackson						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give year or dates of service)						14. MOTHER'S MAIDEN NAME Liza Ann Stewart					
16. SOCIAL SECURITY NO.						17. INFORMANT Address Elizabeth Jackson: 210 Lincoln Ave., Rockville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA 332X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Cerebral vascular thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from June 26, 1961 to July 16, 1961 , that (I) (we) last saw the deceased alive on July 16, 1961 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Victor L. Ramos, M.D.						22b. DATE SIGNED July 16/1961					
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, MD.						22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/19/61			23c. NAME OF CEMETERY OR CREMATORY St. Roses,			23d. LOCATION (City, town or county) (State) Cloppers, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sawney						25a. REC'D BY REGISTRAR JUL 20 '61					
ADDRESS Rockville, Md.						25b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8541

CERTIFICATE OF DEATH

08535

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>34 Hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>148 Greenberry Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1118 East Franklin St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH PAMELIA POTTER</u>		4. DATE OF DEATH Month Day Year <u>July 25 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18 1875</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rohrersville Wash Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas H. Norris</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Catherine Smith</u>		Address <u>59 Main St Keedysville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Myocardial Infarction</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 24, 1961</u> to <u>July 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1961</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>7/26/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/27/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rohrersville Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rohrersville Wash Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25. REC'D BY REGISTRAR <u>[Signature]</u>	
ADDRESS <u>Hagerstown Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>JUL 27 '61</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "DATE" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8542

08536

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hagerstown R # 6 d. STREET ADDRESS Sunrise drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle WILLIAM Last RALLS				4. DATE OF DEATH Month July Day 15 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Dec Day 31 Year 1898	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 6 Days 23		11. IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stereotype operator				11. BIRTHPLACE (County & State, or foreign country) Montgomery Co Front Royal W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Ralls				14. MOTHER'S MAIDEN NAME Catherine Alexander			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-3200		17. INFORMANT Mrs Ella I. Ralls Address 206 Monongalia St Charleston W. Va			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) Cardiovascular collapse (b) Pulmonary Fibrosis (c) Pneumoconiosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Emphysema, lungs							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 13 , 1961, to July 15 , 1961, that (I) last saw the deceased alive on July 15 , 1961, and that death occurred at 11:00 M, from the causes and on the date stated above.							
22a. SIGNATURE Louis G. Craft M.D.				22b. DATE SIGNED 7/17/61		22c. PHYSICIAN'S NAME (Type) Louis G. Craft	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/17/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown Md.				25a. REC'D BY REGISTRAR JUL 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2342

RECORDED

Reprographic Operator

Station 7, Radio

*Our new machine
is now in use
and we are
very pleased
with the results.*

*Lowell
L. L. L.*

ANNEX 1, Southern Engineering Co.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08537

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT#2 HAGERSTOWN CONOCOCHIEAGUE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN d. STREET ADDRESS RT.#2 HAGERSTOWN e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DEBORAH KAY RAUTH		4. DATE OF DEATH JULY 30 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/1956
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALBERT V. RAUTH	
14. MOTHER'S MAIDEN NAME CATHERINE IRENE SHOWE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. ALBERT V. RAUTH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while playing in Conococheague Creek	
20c. TIME OF INJURY Month, Day, Year 6/9 7-30 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Creek		20f. (City or town) Hagerstown (County) Washington (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE A. W. Ditto		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 31, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/2/61	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) HAGERSTOWN MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment		24a. REC'D BY REGISTRAR AUG 3 '61	
ADDRESS Hagerstown, Md		24b. REGISTRAR'S SIGNATURE Charles L. Haver	

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FOR STATE
HEALTH DEPT.

M

Dr. E. N. Dittler, Jr.
Delay is necessary, it is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8544 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
08538											
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b MINUTES d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. Co. Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Route d. STREET ADDRESS 1 Boonsboro MD, R. 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HARRY LUTHER REEDER		4. DATE OF DEATH JULY 23 1961		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY-27-1915 46 yrs.	
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days 4 26		11. IF UNDER 24 HRS. Hours Min. 4 26		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEELAND DIE MAKER		10b. KIND OF BUSINESS OR INDUSTRY FAIRLAND AIRCRAFT		11. BIRTHPLACE (State or foreign country) BENEVOLA WASH. CO. MD. U.S.A.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME HUBERT E. REEDER		14. MOTHER'S MAIDEN NAME ALICE R. HUTZELL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-12-7216		17. INFORMANT MRS. MARY REEDER Boonsboro MD, R. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 24, 1961 Address (Street, city, town, or county)											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. N. Dittler, Jr. 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF JULY 25-1961 22c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery 22d. LOCATION (City, town, or country) (State) Boonsboro WASH. CO. MD. 23. FUNERAL DIRECTOR John A. Best Boonsboro MD. 24e. REC'D BY REGISTRAR JUL 28 '61 24f. REGISTRAR'S SIGNATURE Arthur L. Kane											

MEDICAL CERTIFICATION

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Handwritten signature

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/STW

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8545

08538

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1131 Hamilton Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Jackson Robinson				4. DATE OF DEATH Month Day Year July 8 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1908		9. AGE (In years last birthday) yrs. 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retail- Tires		11. BIRTHPLACE (State or foreign country) Marion, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME W. S. Robinson				14. MOTHER'S MAIDEN NAME Cora Tucker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-09-1109		17. INFORMANT Address Mrs. Eleanor Robinson Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephrosclerosis with uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) Multiple pulmonary emboli PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple pulmonary emboli						INTERVAL BETWEEN ONSET AND DEATH whs 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to July , 19 61 , that (I) (we) last saw the deceased alive on July 7 1961 , and that death occurred at 1:30a AM, from the causes and on the date stated above.							
22a. SIGNATURE Ralph W. Stauffer, M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) John C. Stauffer	
22d. ADDRESS				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-10-61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				25a. REC'D BY REGISTRAR JUL 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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(M)
8548
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08540

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Berkeley	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 218 West Martin Street	
3. NAME OF DECEASED (Type or print) David Lafayette Rosser First Middle Last		4. DATE OF DEATH July 2, 19 61 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Nov. 1867
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY carpenter	
11. BIRTHPLACE (State or foreign country) Harrisonburg, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Rosser		14. MOTHER'S MAIDEN NAME Susan Beeler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Mina Durr, 218 W. Martin Str.		Address Martinsburg, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized arteriosclerosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Prostatitis		INTERVAL BETWEEN ONSET AND DEATH 40 yrs -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1961 to July 2, 1961 , that (I) (we) last saw the deceased alive on June 15, 1961 , and that death occurred at 5:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE F. A. Hamilton		22b. DATE SIGNED July 3, 1961	
22c. PHYSICIAN'S NAME (Type) F. A. Hamilton		22d. ADDRESS Winchester Ave. Martinsburg W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5 July 1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Thomas, Tucker, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leal Williamsport Maryland		25a. REC'D BY REGISTRAR DATE JUL 5 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8547

08541

1. PLACE OF DEATH a. COUNTY WASHINGTON N MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 50 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 1042 S. POTOMAC ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLYDE First SYLVESTER Middle SHANK Last		4. DATE OF DEATH Month JULY Day 13 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK		10b. KIND OF BUSINESS OR INDUSTRY FEED STORE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BARRY O. SHANK		14. MOTHER'S MAIDEN NAME BARBARA SUMMERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-0220	
17. INFORMANT MRS. LELIA H. SHANK		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and Arteriosclerotic Heart Disease DUE TO (c) Disease		INTERVAL BETWEEN ONSET AND DEATH 10 min. 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pancytopenia; arthritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from June 29 1961 to July 13 1961 , that (I) last saw the deceased alive on July 13 1961 , and that death occurred at 11:15 pm M, from the causes and on the date stated above.			
22a. SIGNATURE <i>William T. Layman, M.D.</i>		22b. DATE SIGNED 7-15-61	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/16/61	
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Normant, Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR DATE JUL 18 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>			

CONFIDENTIAL

SECRET

(M)

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of text that are illegible due to extreme fading and bleed-through from the reverse side.]

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8543

Item 9 Film 9292

7/21/61 iwk

08542

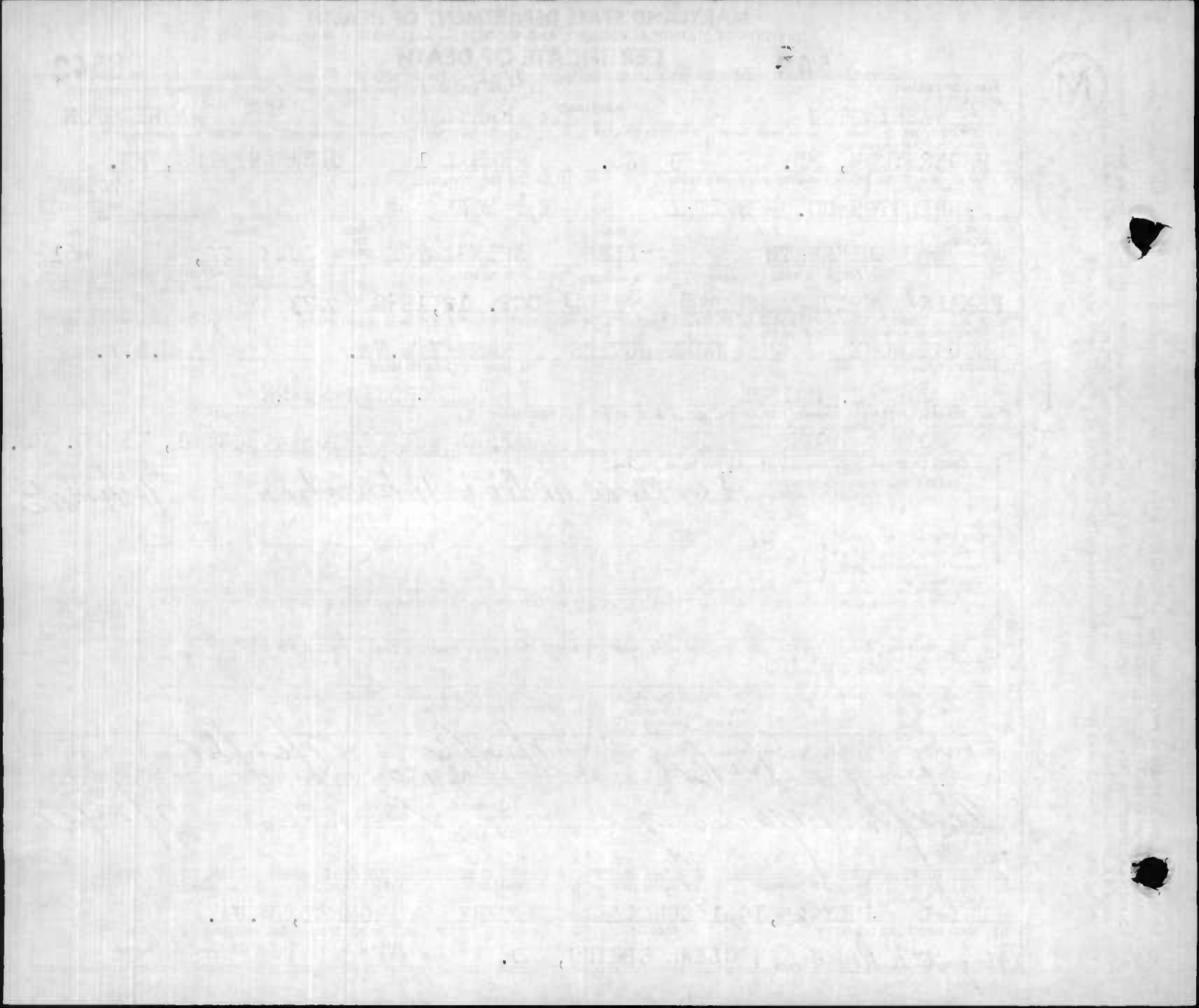
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN, MD.		c. LENGTH OF STAY IN 1b 3 WKS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZEBETH Middle ELLEN Last SHINGLETON		4. DATE OF DEATH Month JULY Day 22 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 12, 1888
9. AGE (In years lost birthday) 72 7/8 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	
11. BIRTHPLACE (State or foreign country) ROMNEY W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. HAINES		14. MOTHER'S MAIDEN NAME LUCRETIA SHANK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT WARREN SHINGLETON		Address ROUTE 1, CLSPG. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ao. Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/22/61 to 7/22/61 , that (I) (we) last saw the deceased alive on 7/22/61 , and that death occurred 3:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE Carlton L. Haines		22b. DATE SIGNED 7/23/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 25, 1961	
23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY		23d. LOCATION (City, town, or county) (State) ROMNEY, W. VA.	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret R. Rowland		25a. REC'D BY REGISTRAR DATE JUL 26 '61	
ADDRESS CLEAR SPRING, MD.		25b. REGISTRAR'S SIGNATURE Carlton L. Haines	

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081



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8549

CERTIFICATE OF DEATH

Reg. Dist. No. 08543

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CYRUS</u> First <u>LESLIE</u> Middle <u>SITES</u> Last		4. DATE OF DEATH <u>July</u> Month <u>14</u> Day <u>19</u> Year <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter & Farmer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter & Farmer (Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Copton, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cyrus Sites</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>187-16-5537</u>	
17. INFORMANT <u>Cora Sites</u>		<u>Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial dilatation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis-thrombosis-myocardial infarction</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostatic hypertrophy. Uremia, due to renal sclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>6 wks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>59</u> , to <u>July 14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 14</u> , 19 <u>61</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>359 East Baltimore St., Greencastle, Penna.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>W.C. Brewer</u> M.D. <u>359 East Baltimore St., Greencastle, Penna.</u> PHYSICIAN'S NAME (Type) <u>W.C. Brewer, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>	22b. DATE THEREOF <u>7/17/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 19 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneib</u>

CERTIFICATE OF DEATH

1952

NAME OF DECEASED <i>James Earl Ray</i>		DATE OF BIRTH <i>May 19 1928</i>		PLACE OF BIRTH <i>London, England</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Writer</i>	
RESIDENCE <i>1000 17th St NW, Washington, D.C.</i>		DATE OF DEATH <i>May 14 1968</i>		PLACE OF DEATH <i>London, England</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		CERTIFICATE NO. <i>12345</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>		SIGNATURE OF DECEASED <i>James Earl Ray</i>	
DATE OF SIGNATURE <i>May 15 1968</i>		DATE OF SIGNATURE <i>May 15 1968</i>		DATE OF SIGNATURE <i>May 15 1968</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8550

08544

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN 1b <u>11 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>206 POTOMAC ST.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> <u>WASHINGTON</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> g. STREET ADDRESS <u>206 POTOMAC ST.</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MYRTLE E. SMITH</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OF RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 17 - 1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FRED. CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EZRA HOUST</u>				14. MOTHER'S MAIDEN NAME <u>LILLY DOAT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. GLENN E. MANN BOONSBORO MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the hip & spine</u> 174X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of the uterus</u> (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>7 MONTHS</u> <u>16 MONTHS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/11/61</u> <u>7/14/61</u> <u>8 P</u> to <u>7/14/61</u> 19 <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>8 P</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter H. Shealy</u> M.D.				22b. DATE SIGNED <u>7/15/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>	
22d. ADDRESS <u>SHARPSBURG WASH. CO. MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 17 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>LOCUST GROVE WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Best</u>				25a. REC'D BY REGISTRAR <u>Boonsboro MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>JUL 19 1961</u>							



Carcinoma of the uterus

Metastatic carcinoma of the hip & spine

7/14/61

Wilder

R.D.

Wilder

Walter H. Shealy M.D.

Wilder

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8551

08545

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>25 Mt. Airy Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Arthur</u> Last <u>Snider</u>		4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1894</u>
9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>15</u> Min. <u>00</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>15</u> Min. <u>00</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Production Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>machine tool ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles D. Snider</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Stewart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>173 03 1136</u>	
17. INFORMANT <u>Mrs. Robert B. Rowe</u>		Address <u>Waynesboro, Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4 20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>(Previous Coronary 8 wks ago)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>15 May 1961</u> to <u>23 July 1961</u> , that (I) (we) last saw the deceased alive on <u>23 July 1961</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. D. Wilson</u>		22b. DATE SIGNED <u>7/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. D. WILSON, M.D.</u>		22d. ADDRESS <u>135 N. POTOMAC ST. HAGERSTOWN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City, town, or county) <u>Waynesboro, Penna.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Halter & Grace</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 27 '61</u>	
ADDRESS <u>Waynesboro, Penna.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

CERTIFICATE OF DEATH

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TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8552

08546

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pinesburg c. LENGTH OF STAY IN lb Lifetime		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pinesburg d. STREET ADDRESS Williamsport RFD # 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edna Dean Staley		4. DATE OF DEATH Month Day Year July 14 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1876	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 4 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Pinesburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Banzhoff		14. MOTHER'S MAIDEN NAME Mary Ann Null	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war and date of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Banzhoff Williamsport, Md. RFD #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/14/61 19....., to 7/14/61 19....., that (I) (we) last saw the deceased alive on 7/14/61 19....., and that death occurred at 4:40 M., from the causes and on the date stated above.			
22a. SIGNATURE Robert L. Young		22b. DATE SIGNED 7/15/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 16, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City, town or county) (State) Near Clearspring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md.		24. ADDRESS	
25a. REC'D BY REGISTRAR DATE JUL 18 '61		25b. REGISTRAR'S SIGNATURE William S. Thomas	

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Look for records in box 10

Handwritten notes and signatures at the bottom of the page.

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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

8553 **MARYLAND STATE DEPARTMENT OF HEALTH**
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08547

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>2 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		d. STREET ADDRESS <u>669 Highlandway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>30 Summit Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Norman Michael Stauffer</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1924</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>Bainbridge, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Peter W. Stauffer</u>				14. MOTHER'S MAIDEN NAME <u>Ellen L. Reno</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W. W. 11 649-36-7570</u>		17. INFORMANT <u>Mrs. Geraldine C. Stauffer Hag. Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420. Mitral Stenosis</u> DUE TO <u>Cardiac Hypertrophy & Dilatation</u> (b) <u>Mural Thrombus, Left Atrium</u> DUE TO <u>Pulmonary Congestion</u> (c) <u>Coronary Atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u> </u>		<u>July 18, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-21-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or country) (State) <u>Lancaster, Pa.</u>	
23. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 20 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8554 Item 9 Film G291 6/21/61 inv

08548

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>5 yrs-1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Shippensburg, Pennsylvania</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Shippensburg, Pennsylvania</u> d. STREET ADDRESS <u>400 W. King Street</u>			
3. NAME OF DECEASED (Type or print) <u>Guy</u> First <u>Staver</u> Middle Last				4. DATE OF DEATH <u>July</u> Month <u>17</u> Day <u>1961</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 13, 1891</u> 9. AGE (In years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Newburg, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alonza Staver</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Bother</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Guy Staver</u>				Address <u>400 W. King St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion (acute)</u> DUE TO (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Pyoderma</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyoderma</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 25, 1958</u> to <u>7-18, 1961</u> , that (I) (we) last saw the deceased alive on <u>7-15, 1961</u> , and that death occurred at <u>4:25 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>M. E. Byrkit</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-18-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>				22d. ADDRESS <u>Williamsport, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Jul 19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Shippensburg-Cumberland, Pa</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Alton C. Hess</u>				24a. REC'D BY REGISTRAR <u>Jul 19 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8555

08549

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 34 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1516 Chestnut Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) William Augustus Stump		4. DATE OF DEATH July 14, 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 13, 1919		9. AGE (In years, last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Engineer				10b. KIND OF BUSINESS OR INDUSTRY Construction Co.				11. BIRTHPLACE (County & State, or foreign country) Flint, Michigan				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles W. Stump				14. MOTHER'S MAIDEN NAME Rose Spicer				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or date of service) W.W. II				16. SOCIAL SECURITY NO. 213-12-7186				17. INFORMANT Mrs. Frances Stump Address Hagerstown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) generalized carcinomatosis 153.3 DUE TO (b) carcinoma of sigmoid colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 16 months				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 10, 1961 to July 14, 1961 , that (I) (we) last saw the deceased alive on July 14, 1961 , and that death occurred at 10:45 A.M. from the causes and on the date stated above.																			
22a. SIGNATURE Victor L. Ramos, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED July 14, 1961											
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.				22d. ADDRESS Western Maryland State Hospital, Hagerstown, Maryland.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/18/1961				23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Boyer				ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR JUL 18 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

(M)

(1)

Washington

Washington

30 years

210 Chestnut Street

Washington, D.C.

September 12, 1910

White

Male

Information in answer to question of Mr. J. H. ...

John ...

Charles ...

... 213-12-115 ... Mr. Francis ...

Washington

Washington

East Haven Cemetery

8/8/1901

Special

Letter - General ...

TO REMAIN IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

<div>1</div> <div>M</div> <div>08</div> <div>I</div>												<div>8555</div> <div>08550</div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Washington</div> <div>MARYLAND</div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Hagerstown</div> <div>c. LENGTH OF STAY IN 1b</div> <div>most of life</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Washington County Hospital</div>												<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Washington</div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Hagerstown</div> <div>d. STREET ADDRESS</div> <div>128 Calvert Terrace</div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>3. NAME OF DECEASED (Type or print)</div> <div>First</div> <div>JOSEPH</div> <div>Middle</div> <div>BURTON</div> <div>Last</div> <div>TOWNSHEND</div>						<div>4. DATE OF DEATH</div> <div>Month</div> <div>July</div> <div>Day</div> <div>1</div> <div>Year</div> <div>1961</div>																	
<div>5. SEX</div> <div>male</div>		<div>6. COLOR OR RACE</div> <div>white</div>		<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div>February 18, 1896</div>		<div>9. AGE (In years last birthday)</div> <div>65 yrs.</div>		<div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div>		<div>IF UNDER 24 HRS.</div> <div>Hours</div> <div>Min.</div>											
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>District manager</div>						<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>insurance company</div>		<div>11. BIRTHPLACE (County & State, or foreign country)</div> <div>Westminister, Maryland</div>				<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>											
<div>13. FATHER'S NAME</div> <div>Jeremiah Belt Townshend</div>						<div>14. MOTHER'S MAIDEN NAME</div> <div>Hanna Mary Ecker</div>																	
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)</div> <div>Yes</div>				<div>16. SOCIAL SECURITY NO.</div> <div>W.W. I & II 219-28-5984</div>		<div>17. INFORMANT</div> <div>Mrs. Philippa Townshend</div>				<div>Address</div> <div>Hagerstown, Md.</div>													
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Cerebral thrombosis</div> <div>260X</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b)</div> <div>Diabetes Mellitus</div> <div>(c)</div> <div>Hypertensive cardiovascular disease</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</div>												<div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>3 weeks</div>											
<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>																							
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div>				<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div>																			
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m.</div> <div>p.m.</div> <div>19</div>		<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>		<div>20f. (City or town)</div>		<div>(County)</div>		<div>(State)</div>													
<div>21. I certify that (I) (this hospital) attended the deceased from June 1, 1961 to July 1, 1961, that (I) (we) last saw the deceased alive on July 1, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.</div>																							
<div>22a. SIGNATURE</div> <div>R. S. Stauffer</div>						<div>ATTENDING PHYS.</div> <div><input checked="" type="checkbox"/></div>		<div>MED. DIRECTOR <input type="checkbox"/></div>		<div>STAFF PHYS. <input type="checkbox"/></div>													
<div>22c. PHYSICIAN'S NAME (Type)</div> <div>R. S. STAUFFER</div>						<div>22d. ADDRESS</div> <div>Hagerstown, Md</div>		<div>22b. DATE SIGNED</div> <div>July 3, 1961</div>															
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>		<div>23b. DATE THEREOF</div> <div>7/6/1961</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Arlington National Cemetery</div>				<div>23d. LOCATION (City, town or county)</div> <div>Arlington Va.</div>															
<div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>Butler - Bouzer Funeral Home</div>						<div>ADDRESS</div> <div>Hagerstown, Md.</div>		<div>25a. REC'D BY REGISTRAR</div> <div>DATE JUL 7 '61</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Kraus</div>													

(M)

(1)

Harrison

Harrison

Harrison County Hospital

1980 United States

x

with

February 1, 1980

Insurance company, Harrison, Maryland

Insurance company, Harrison, Maryland

Harrison County Hospital

Harrison County Hospital

1980-1981

1980-1981

Harrison County Hospital

Harrison County Hospital

Harrison County Hospital

1980-1981

1980-1981

1980-1981

Harrison County Hospital

Harrison County Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exposed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
8557													
08551													
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> c. LENGTH OF STAY IN 1b <u>10 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gateway Convalescent Home</u>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Smithsburg R # 2</u> d. STREET ADDRESS <u>None</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Virginia</u> Last <u>Varner</u>						4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>19 61</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1878</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Henry Kershner</u>						14. MOTHER'S MAIDEN NAME <u>Annie M. Stotler</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>None</u>						17. INFORMANT <u>Mr. Edgar W. Varner R # 2 Smithsburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 16, 1961</u> to <u>July 17, 1961</u> that (I) (we) last saw the deceased alive on <u>July 17, 1961</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>David R. Brewer M.D.</u>						22b. DATE SIGNED <u>7/18/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>						22d. ADDRESS <u>Clear Spring Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 20, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beautiful View Cemetery</u>		23d. LOCATION (City, town or county) <u>Middleburg</u>		23e. (State) <u>Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Host</u>						ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>Jul 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

M

1890

0-7-89

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8558

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08552

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				d. STREET ADDRESS 146 N. Jonathan Street			
3. NAME OF DECEASED (Type or print) First Bailey Middle Walker Last Walker				4. DATE OF DEATH Month July Day 2 Year 1961			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 2 1900		9. AGE (In years last birthday) yrs. 60	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Building const.		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA.				13. FATHER'S NAME Bailey Walker Sr.			
14. MOTHER'S MAIDEN NAME Mary French				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 217-09-9924				17. INFORMANT Address Christine Lyles, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of Rt. lung DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of Rt. lung DUE TO (c) 13 months							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) lobular pneumonia, left lung (b) old posterior wall infarction (c) Hydronephrosis, left kidney							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from June 2, 1960 to July 2, 1961 , that (I) (we) last saw the deceased alive on July 2, 1961 , and that death occurred at 5:05 M, from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED July 2, 1961		22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-7-1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr Hagerstown Md				25a. REC'D BY REGISTRAR DATE JUL 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Funn	

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8559

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08553

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Terry Middle Wetzel Last Walker				4. DATE OF DEATH Month 7 Day 10 Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 - 7 - 61	
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.		11. AGE (In years last birthday) yrs.		12. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wetzel B. Walker				14. MOTHER'S MAIDEN NAME Glenna Mae Bragg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Wetzel B. Walker				Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Frank Breuch Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/7 19 61 , to 7/10 19 61 , that (I) (we) last saw the deceased alive on 7/10 19 61 , and that death occurred at 11 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Paul Harrison				22b. DATE 7-10-61			
22c. PHYSICIAN'S NAME (Type) Paul Harrison, M. D.				22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7-13-61		23c. NAME OF CEMETERY OR CREMATORY End of the Trail		23d. LOCATION (City, town, or county) (State) Sam Blacks W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Kraiss Funeral Home				25a. REC'D BY REGISTRAR Hagerstown, Md.			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				DATE JUL 11 '61			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G292 8/9/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

08554

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WARREN, HENRY First Middle Last WARREN		4. DATE OF DEATH Month Day Year July 29, 1961 19	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> unknown WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) RICHMOND, VA.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address MEDICAL RECORD - WASH. CO. HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 1 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 27, 1961 to July 29, 1961 , that I last saw the deceased alive on July 28, 1961 , and that death occurred at 3:50 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8/1/61 DATE SIGNED			
ACTUAL SIGNATURE Paul Harrison M.D.		DATE SIGNED 8/1/61	
PHYSICIAN'S NAME (Type) PAUL HARRISON		318 N. Potomac St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8.1.61	22c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 3 '61	24b. REGISTRAR'S SIGNATURE John S. Harris

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12



Reference

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of the

Washington County Hospital

1207 Rhode Island Ave.

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November 1, 1911

Statement

David A. Wells

Illinois

Mr. Wells, State Police, Springfield

LACERATION OF LIVER WITH IRREVERSIBLE

SHOCK DUE TO BLEED LOSS.

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GOING WRONG WAY IN THE WAY ST. STRUCK ONCOMING CAR.

11:00 PM 7-1-11

125 N. BERRY ST. WASHINGTON, WASH., D.C.

DR. E.V. DITTO, JR.

July 12, 1906

Dr. E.V. Ditt, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8562 CERTIFICATE OF DEATH 08556											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 Yr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>16555 Emory Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LAWRENCE</u> First <u>A</u> Middle <u>WHITTAKER</u> Last <u>Lawrence A. Whittaker</u>						4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 25 1901</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island Pawtucket Providence Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Record</u>						14. MOTHER'S MAIDEN NAME <u>No Record</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-07-6197</u>		17. INFORMANT <u>Mrs Marilyn W. Johns</u> Address <u>16555 Emory Lane Rockville Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purpura Hemorrhagica</u> DUE TO <u>292.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aplastic Anemia</u> DUE TO (c) <u>1 MONTH</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Rheumatoid arthritis ② Psoriasis ③ Auricular Fibrillation</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> <u>1960</u> to <u>July 6</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>July 6</u> <u>1961</u> , and that death occurred at <u>4:55 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>July 6, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>						22d. ADDRESS <u>Western Maryland State Hospital Hagerstown, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>						25a. REC'D BY REGISTRAR <u>JUL 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			

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Andrew K. Gollan, Haverhill, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8563 CERTIFICATE OF DEATH 08557											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 40 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garlock Nursing Home						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1917 Gay St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Harry Franklin Williar						4. DATE OF DEATH July 26 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Aug. 22, 1890						9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Forman						10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Near Thurmont, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry I. Williar						14. MOTHER'S MAIDEN NAME Margaret C. Eby					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes						16. SOCIAL SECURITY NO. 705-10-5954		17. INFORMANT Fred Williar Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 7-25-61 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 7-25-61 , 19 61 , to 7-26-61 , 19 61 , that (I) (we) last saw the deceased alive on 7-25-61 , and that death occurred 4:15 M, from the causes and on the date stated above. 22a. SIGNATURE A. E. White M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) A. E. White 22d. ADDRESS Hagerstown, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7-29-61 23c. NAME OF CEMETERY OR CREMATORY U. B. Cemetery 23d. LOCATION (City, town or county) (State) Thurmont, Md. 24. FUNERAL DIRECTOR'S SIGNATURE Scott. F. Minnich & Son ADDRESS Hagerstown, Md. 25a. REC'D BY REGISTRAR JUL 31 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Finner											

1933

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Washington

Barrett

10:00 am

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Method: Pressing Room

10:00 am

Harry Franklin Miller

10:00 am

John White

10:00 am

Section: Open

10:00 am

Harry I. Miller

10:00 am

W. V. I.

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Report: E. Simpson & Son, Georgetown, Md.